WISCONSIN SCHOOL COUNSELORS' PERCEPTIONS

OF STUDENT SELF-INJURY

by

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A Research Paper

Submitted in Partial Fulfillment of the
Requirements for the
Education Specialist Degree
With a major in

School Psychology

Approved: 6 Semester Credits

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Title:	***Wisconsin School Counselors' Perceptions of Student Self-Injury***
Graduate Degree/Major:	**Ed.S. School Psychology**
Research Advisor:	**Helen Swanson, Ph.D.**
Month/Year:	**May, 2007**
Number of Pages:	**73**
Style Manual Used:	**American Psychological Association, 5th edition**

ABSTRACT

The purpose of this project was to provide general information regarding self-injury in the adolescent population, as well as gain information related to Wisconsin school counselors' perceptions of student self-injury. This literature review addressed various aspects of self-injury, including the following: typical characteristics of self-injurers; possible reasons as to why individuals self-injure; treatment option; and recommendations for those who work with self-injurers. A critique of the current research and recommendations for future research are also included.

This research addressed Wisconsin school counselors' initial and current perceptions of student self-injury. Additional objectives were to gain information regarding associations between their perceptions and training, years of experience as a counselor, and experience with students who self-injure. Several positive associations

were found. Interpretation of the results, as well as recommendations for future research, were included.

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Acknowledgements

I would like to take the opportunity to thank all of the staff who have been so important in my graduate education. I would like to thank Denise Maricle, Jackie Weissenburger, Denise Brouillard, and Barb Flom for providing real-life insight into school psychology and school counseling. In addition, I would like to thank Helen Swanson for being a very patient and understanding thesis advisor and professor, as well as providing wonderful insight into my paper. I would also like to thank Amy Gillett for being a knowledgeable professor and advisor for my master's thesis. I would also like to thank Christine Ness for the statistical analysis related to my survey. In addition, I would like to thank those involved with the UW-Stout Student Research Fund for their generous grant support. I am also grateful to Linda Dahl, who was of great assistance in helping coordinate my grant information.

I also want to thank my parents and my husband for providing additional support during my graduate school experience.

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Chapter I: Introduction

Self-injury is a growing concern among parents, teachers, counselors, and other school and medical personnel. Self-injury is also a topic receiving increased interest from the press (Ross & Heath, 2002; Alderman; Pedersen; Pipher; Schappell; Steinem; Todd; cited in Zila & Kiselica, 2001). According to the Self-Abuse Finally Ends (S.A.F.E.) Alternatives® Program (2002), approximately 1% of the population self-injures on a regular basis. According to Ross and Heath (2002), self-injury occurs in one out of ten high school-aged students. More importantly, self-injury is a confusing behavior due to a lack of encompassing definitions, multiple causes for the behavior, a shortage of information, a scarcity of treatment programs, and the need for more understanding on behalf of parents and professionals.

Self-injury has many names. These names include, but are not limited to, the following: self-mutilation (Clarke & Whittaker, 1998; Suyemoto & MacDonald, 1995; Zila & Kiselica, 2001), self-cutting (Himber, 1994; Greenspan & Samuel; cited in Zila & Kiselica, 2001), and self-destructive behavior (Van der Kolk, Perry, & Herman; cited in Zila & Kiselica, 2001). Martinson (cited in Anderson & Preuss, 2002b) asserted many self-injurers dislike terms such as self-mutilation. She suggested other terms such as self-injury, self-harm, and self-inflicted violence. Due to the fact that self-injury is described in many different ways by different researchers, all terms are used interchangeably in this paper. The two most commonly used terms are self-injury and self-mutilation.

Self-injury also displays itself in many different forms. One of the most common forms is cutting (Anderson & Preuss, 2002a; Ross & Heath, 2002; S.A.F.E. Alternatives® Program, 2002; Zila & Kiselica, 2001). There are many other forms,

including burning (Anderson & Preuss, 2002a; Favazza & Conterio, 1988; Pattison & Kahan; Pipher; Van der Kolk, et al.; cited in Zila & Kiselica, 2001), scratching to excess, ingesting sharp and/or toxic objects, self-hitting (Ross & Heath, 2002), head banging, and the amputation of body parts such as arms, legs, fingers, and breasts (Anderson & Preuss, 2002a). These forms are a few of the many used by self-injurers. The S.A.F.E. Alternatives Program® (2002) stated many self-injurers use several forms of self-injurious behavior. Yet, in a study by Ross and Heath (2002), the majority of adolescents reportedly used only one form of self-injury. As Zila and Kiselica (2001) suggested, self-injurers will use whatever means they can devise.

According to most research, self-injury is more common in women than in men. According to Conterio and Lader (1998), there are several possible reasons why there are more female self-injurers than male self-injurers. In many instances, it is more socially acceptable for males to act outwardly than it is for females, leading females to express anger towards themselves (Ross & Heath, 2002). Males are more likely to be aggressive towards others or participate in other forms of risk taking behavior (Ross & Heath). Conterio and Lader (1998) also stated that men are less likely to seek professional help and are more likely to use drugs and alcohol. Due to a scarcity of research regarding male self-injurers, female self-injurers are the population of the research presented in this literature review.

Another pressing concern involves the characteristics of self-injurers. Self-injurers cannot be confined to one simple category. One characteristic of self-injurers is that they are primarily female. Self-injurers are present in upper, middle, and lower class families, but the "typical" self-injurer is a middle class female (Anderson & Preuss,

2002a). There are no racial or educational boundaries identified in the research (Anderson & Preuss, 2002a). The typical self-injurer often has an average to a high level of intelligence. A self-injurer will typically begin injuring herself at the onset of puberty (Anderson & Preuss, 2002a; Zila & Kiselica, 2001). According to Martinson (cited in Anderson & Preuss, 2002b), self-injury can occur from puberty through the sixties, and, possibly, older. In addition, self-injurers often have low self-esteem (Anderson & Preuss, 2002a; Nichols, 2000; S.A.F.E. Alternatives® Program, 2002). According to the S.A.F.E. Alternatives® Program, approximately 50% of self-injurers have been physically, sexually, and/or mentally abused. Ninety percent of self-injurers were not allowed to express their feelings. Literature from the S.A.F.E. Alternatives® Program also stated that over 50% of self-injurers have some form of an eating disorder. In addition, a connection between self-injury, alcohol, and other substance abuse has been established (S.A.F.E. Alternatives® Program, 2002; Zila & Kiselica, 2001).

There are a variety of factors that lead to self-injury. As stated above, many self-injurers have had some form of abuse in their past. As they get older, repressed feelings in childhood can often cause children to feel empty and unable to express their feelings (Anderson & Preuss, 2002a; Nichols, 2000; S.A.F.E. Alternatives® Program, 2002). Many self-injurers describe an inability to form relationships and a lack of feeling loved and accepted (Anderson & Preuss, 2002a; Nichols, 2000; S.A.F.E. Alternatives® Program, 2002). Martinson (cited in Anderson & Preuss, 2002b) believed self-injurers might be trying to stop flashbacks or ideas of self-hate. Martinson also stated that self-injurers might have a biological predisposition to hurt themselves.

One of the most important distinctions that must be made is that self-injurers are not attempting suicide. The S.A.F.E. Alternatives® Program (2002) defined self-injury as the following: "The behavior is defined as the deliberate, repetitive, impulsive, non-lethal harming of one's self" (n.p.). Another definition, given by Martinson (cited in Anderson & Preuss, 2002b), is as follows: "Most researchers agree that self-injury (SI) is self-inflicted harm severe enough to cause tissue damage or marks that last for several hours, done without suicidal intent or intent to attain sexual pleasure" (n.p.). In some instances, self-injurers may kill themselves (Nichols, 2000), but according to Conterio and Lader (1998), the self-injurers who committed suicide suffered from long-term and severe forms of depression. Conterio and Lader (1998) and Nichols (2000) further asserted that a self-injurer might accidentally cut too deeply, resulting in a suicide. Conterio and Lader described several differences between suicide attempts and self-injury. They described self-injury as a way to prevent suicide because it helped the self-injurer cope with their current needs. The authors also stated that most self-injury was superficial and not a common way of ending one's life. Further they claimed many self-injurers were offended when accused of attempting suicide.

Self-injury is a very misunderstood condition. Martinson (cited in Anderson & Preuss, 2002b) suggested doctors and emergency workers should treat these injuries as accidental. Martinson stated that denying services or making negative comments is not in the best interest of the patient. The patient will not feel comfortable returning to the hospital if they are mistreated, which can lead to other complications such as infections or future injuries (Martinson, cited in Anderson & Preuss, 2002b).

Statement of the Problem

The purpose of this study was to determine the perceptions of school counselors in Wisconsin public schools regarding the act of student self-injury. Additional research objectives were to gain information regarding school counselors' training, years of experience as a school counselor, and their experience with students who self-injure.

Rationale

The rationale for this literature review was to increase knowledge and awareness about self-injury and the individuals who self-injure through an extensive literature review. The rationale for the research investigation component of this study was to provide insight about the perceptions of school counselors in Wisconsin who work with students who self-injure.

Research Questions

This study sought to answer the following questions:

1. What is the current research information on adolescent self-injury?
2. What are school counselors' perceptions about self-injury?
3. What are school counselors' perceptions of those who self-injure?
4. What are the associations between school counselors' training and their experience with students that self-injure?
5. Are there connections between school counselors' years of experience and their experience with students that self-injure?
6. Are there correlations between school counselors' initial and current perceptions of student self-injury and their experience with students that self-injure?

Definition of Terms

There is one term that requires a definition to clarify the nature of this paper. This term is self-injury.

> Self-injury: This behavior is defined as the deliberate, repetitive, impulsive, non-lethal harming of one's self. Self-injury includes: (1) cutting; (2) scratching; (3) picking scabs or interfering with wound healing; (4) burning; (5) punching self or objects; (6) infecting oneself; (7) inserting objects in body openings; (8) bruising or breaking bones; (9) some forms of hair pulling, as well as other forms of bodily harm (S.A.F.E. Alternatives® Program, 2002, n.p.)

This term does not include self-injury related to sexual pleasure (Martinson, cited in Anderson & Preuss, 2002b). This term also does not include eating disorders. Tattooing and piercing are not considered self-injury, unless a physical "high" and repetitive needs are gained through the tattooing and/or piercing.

Assumptions

It was assumed that school counselors in this study may have had some form of exposure to information about self-injury, either through individualized readings, seminars, or in-services. It was also assumed that school counselors may have had counseling experience with students who self-injured. It was further assumed that counselors would have opinions regarding reasons for self-injury. There was an assumption that the potential sample size would provide a representative view of school counselors' perceptions regarding self-injury in the state of Wisconsin. It was assumed that the survey would be an adequate measure of the school counselors' perceptions. A

final assumption was that the survey would be answered honestly and returned in a timely fashion.

Limitations

One limitation of this study is that not all forms of self-injurious behavior, such as drug and alcohol abuse and/or dependency and eating disorders, were included. Another limitation of this study is that the technical adequacy, including reliability and validity, of the survey instrument, has not been examined. Further, only school counselors from the state of Wisconsin were asked to participate in the study; therefore, any results obtained from this study should not be generalized to counselors in other states or districts, or to other professionals.

Methodology

Chapter two is a review of the literature, including the types of self-injury, ways to work with self-injury, treatment information, and recommendations. Chapter three addresses information related to the methodology of the quantitative study. Chapter four addresses data analysis, and chapter five provides a discussion of the results.

Chapter II: Literature Review

Introduction

This chapter is focused on factors that may lead to self-injury. These influencing factors include: childhood abuse, psychological disorders connected with self-injury, substance abuse, eating disorders, body image, and maladaptive coping styles. An additional focus area is treatment options for self-injurers, including medications, residential or inpatient placements, and some outpatient therapy. The chapter concludes with recommendations for individuals who work with self-injurers.

Influencing factors

Favazza and Conterio (1989) conducted a study regarding numerous aspects of self-injury including abuse, personal attributes, and sexuality ($n = 254$). Many self-injurers have a history of abuse. According to Favazza and Conterio, approximately 62% of their participants reported abuse during childhood and adolescence. The two most common forms of abuse reported by self-injurers were sexual and physical abuse. In Favazza and Conterio's study, 29% of the participants were victims of sexual and physical abuse, while 16% were physically abused and 17% reported only sexual abuse. Some self-injurers reported emotional abuse or neglect, as well. In a comparison study of sexually abused self-mutilators and non-mutilators, 50% of those who self-injured were more likely to have their father as the abuser (Turell & Armsworth, 2000). The results from Favazza and Conterio (1989) suggested that the primary perpetrator of the abuse was a family friend (43%), followed by a brother (25%), and then a father (23%). According to Turell and Armsorth (2000), self-injurers suffered abuse earlier in life and

for a longer period of time. Turell and Armsworth also discussed the importance of emotional abuse in their study. The participants were:

> Nine times as likely to feel not wanted by their family, ten times more likely to feel a burden to their family, five times as likely to wish they hadn't been born, twice as likely to feel isolated and alone, and over three times more likely to identify as the family scapegoat (p. 242).

An important distinction must be made regarding abuse and the occurrence of self-injury. Not every person who self-injures was abused and not every person who was abused self-injures. Self-injurers have different reasons for engaging in this behavior and it is not fair to them, as individuals, to assume there is one, specific reason for their behaviors.

Conterio and Lader (1998) discussed an important link between self-injury and abuse. In most circumstances, a bond forms between a parent and a child at the time of birth. In instances where a child was abused, this bond may not have been established. According to Conterio and Lader, this bond can be damaged for several reasons. The mother may have suffered from depression or other psychiatric illness. Conterio and Lader also discussed other reasons that may contribute to difficulties at some point in the bonding process. These reasons include divorce, moving to a new location, and a death or life-threatening illness of a family member (Conterio & Lader; Turell & Armsworth, 2000). Many families encounter situations similar to these, but Conterio and Lader (1998) distinguished abusive parents as being emotionally fragile. Parents who are emotionally fragile are unable to give their child adequate care, including touching and holding the child. Conterio and Lader believed those who self-injure do so because their "skin

boundaries were not respected, so her recognition or appreciation of those boundaries could not develop normally" (p. 75). Clarke and Whittaker (1998) described the skin distinction as the following:

> Skin is symbolically important not only because it is the barrier upon which damage is inflicted but also because it portrays by its color and condition a gamut of emotions: rage, fear, embarrassment, and so on. In many ways, it is the border between the outside world and the inner world, the environment and the self (Favazza & Rosenthal, cited in Clarke & Whittaker, 1998), a living canvas by which a person-by marking or damaging-communicates a range of ideas and emotions. (p. 130)

Another way to address this connection is that the body serves as a boundary between what is part of oneself and what is not. If an individual injures the body, they are able to distinguish what is a part of them and what is part of the environment (Zila & Kiselica, 2001).

Self-injury is not a separate classification in the *Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition* (Conterio & Lader, 1998; Muehlenkamp, 2005). Self-injury is a symptom of several other diagnoses, but self-injurers may or may not be diagnosed with a disorder. There are several diagnoses under which self-injurers may be classified, such as depression and bipolar disorder (Conterio & Lader). In a study done by Ross and Heath (2002), it was found that many of the students who self-injure reported higher levels of depressive symptoms. Results suggested that the levels of depressive symptoms might be used to differentiate self-injurers from those who do not

self-injure. Some self-injurers may also be misdiagnosed as having bipolar disorder because of their intense mood swings, which include manic and depressive symptoms.

Other self-injurers are classified under another category, anxiety disorders. Conterio and Lader (1998) stated many self-injurers often suffer from panic attacks, tension, and are easily agitated. In a study done by Ross and Heath (2002), students who self-injured had higher levels of anxiety symptoms. Conterio and Lader (1998) asserted that some caution should be exercised when self-injurers are diagnosed as having an anxiety disorder. The main caution involved the use of medication and the need for many self-injurers to deaden their feelings, which may lead to an accidental or intentional overdose.

Conterio and Lader (1998) stated self-injurers could suffer from thought disorders such as schizophrenia or have symptoms of thought disorders, such as hallucinations or delusions. Some self-injurers who were abused may be given the diagnosis of Post Traumatic Stress Disorder (PTSD). In a study done by Albach and Everaerd (cited in Turell & Armsworth, 2000), 25% of their incest survivor participants suffered from PTSD and participated in self-injurious behaviors. Depersonalization disorder and dissociative identity disorder (formerly known as multiple personality disorder) are other diagnoses for those who self-injure.

The most common diagnosis assigned to self-injurers is Borderline Personality Disorder (BPD) (Clarke & Whittaker, 1998; Conterio & Lader, 1998). Some characteristics of BPD include: impulsivity, mood swings, feelings of emptiness and boredom, disturbances in identity, and a history of unstable relationships (Conterio & Lader, 1998).

Another characteristic of many self-injurers is the abuse or dependence on alcohol and other drugs. This issue can be seen from different viewpoints. According to Pattison and Kahan, and Graff and Mallin (cited in Zila & Kiselica, 2001), issues with drugs and alcohol can predispose someone to self-injure. On the other hand, Ross and McKay (cited in Zila & Kiselica, 2001) believed that abusing alcohol and drugs is a form of self-injury. Either way, some individuals who self-injure have difficulties and concerns with drug and alcohol abuse/dependency.

In some cases, self-injury and eating disorders occur concurrently, or one behavior will replace another (Zila & Kiselica, 2001). For example, a person may start with an eating disorder and complete a treatment program, but will replace the eating disorder with another form of self-injurious behavior. In a study done by Favazza and Conterio (1988), 61% of their study participants who self-injured also had an eating disorder at some point in their lives.

According to Conterio and Lader (1998), individuals who self-injure and have an eating disorder are often trying to make themselves as unattractive as possible so they will not be raped or violated again. Thus, those individuals are either trying to starve themselves or make themselves obese to hide feminine attributes to increase their unattractiveness. Conterio and Lader also stated that eating disorders and self-injury are ways to seek revenge for the cruel injustices during their life. Some may shave their head or pull out their hair (Conterio & Lader, 1998). They may also wear baggy clothes or masculine attire to hide their bodies (Conterio & Lader).

There is a strong link between body image and self-injury. According to Conterio and Lader (1998), many of their patients disliked their bodies and detested having a

menstrual cycle. In addition, individuals with abnormal menstrual cycles were found to be more likely to self-injure (Zila & Kiselica, 2001). In their study, Favazza and Conterio (1989) stated:

> The normalcy of their sexual anatomy was questioned by 18% of subjects, 34% hated their breasts, 58% their periods, and 56% strongly hated to have a pelvic exam; 19% said they would be better off without a vagina, and 10% sometimes harmed themselves in an attempt to stop a periods from beginning or to make it end sooner" (p. 284-285).

According to Conterio and Lader (1998), some women will insert sharp objects into their vagina in case they are attacked. Even though this hurts, they would rather hurt themselves than have someone inflict injury on them. One of Conterio and Lader's patients, Rosa, stated the following with regards to herself: "I have never been comfortable with my body. I didn't like being short and stocky. I have not particularly felt it okay to be a woman, to be feminine, to be sexy" (p. 109).

Self-injurers are often at odds with their sexuality. According to Zila and Kiselica (2001), individuals who self-injure are sometimes unable to handle their sexuality because it may be inhibited from current or previous unwanted sexual attacks. Some are unsure of their sexual identity (Conterio & Lader, 1998; Ponton, cited in Rochman, 2000), and some do not receive pleasure from sexual intimacy (Conterio & Lader, 1998). Due to being uncomfortable with sexuality, Conterio and Lader stated many of their patients prefer contact, such as cuddling, to genital contact.

There are many reasons why a person may resort to self-injury. Childhood abuse, eating disorders, psychological disorders, and body image can influence the need to self-

injure. Maladaptive coping styles may also lead to self-injury. Self-injurers often lack a positive home environment where parents have appropriate coping skills. Therefore, these individuals do not learn to model appropriate coping skills. Often, they are left to their own devices; and, ultimately, they choose self-injury as a way to alleviate their stress and unwanted feelings (Haines & Williams, 1997; Nichols, 2000). According to Briere and Gil (1998), self-mutilating behavior acts as a negative reinforcer because they are "rewarded by their capacity to reduce distress, and thereby increase the likelihood that it will be used in the future" (p. 610).

One self-injurer, Kelly, described her self-injury as being a poor self-preservation tactic that allowed her to release pain and gain control (Rochman, 2000). Nichols (2000) and Pattison and Kahan (cited in Clarke & Whittaker, 1998) stated that self-injury is an effective coping mechanism that becomes addictive. Conterio and Lader (1998) described a theory called the pressure cooker theory. This theory is a fallacy, but is often used to describe self-injurers who need to rid themselves of uncomfortable thoughts and ideas. This desire causes them to release their anger in an explosive manner by punching a pillow, purging their food, or cutting their skin (Conterio & Lader).

Treatment

Needless to say, self-injury may be cathartic for the individual who uses it to help with their feelings. A goal of many therapies is to help the self-injurer handle her feelings in appropriate ways. In the following section, the focus will be on different forms of treatment. These forms will include medication and inpatient and outpatient services.

The first form of treatment discussed here is medication. Conterio and Lader (1998) believe that medication is not the answer to self-injurious behaviors. They believe

that psychotherapy is the best form of treatment, but medication can work to alleviate symptoms that correspond with some disorders. If a self-injurer suffers from depression or bipolar disorder, they may take medication to help alleviate their depressive or manic symptoms. One form of medication that can be prescribed is antidepressants. Some of the more common antidepressant medications are Zoloft, Paxil, and Prozac. Conterio and Lader (1998) discussed some of the benefits of mood stabilizing medications in patients with or without bipolar disorder. These medications include: Lithium, Tegretol, Depakote, and Neurontin.

Anxiolytics are another group of medications used to treat self-injurers. Medications under this category are used to lessen the anxious feelings in those who suffer from anxiety disorders. Conterio and Lader (1998) warned against the use of these drugs because self-injurers may accidentally or intentionally overdose due to the numbing feelings that the medication produces. Conterio and Lader also caution the use of Xanax because it may increase the occurrence of self-injurious behaviors.

Antipsychotic medications can be used with self-injurious individuals who suffer from thought disorders, such as schizophrenia or obsessive-compulsive disorder. An antipsychotic medication, such as Clozapine, is a newer medication that does not have as many side effects as older antipsychotic medications (Conterio & Lader, 1998).

Individuals with dissociative disorders, such as depersonalization disorder or dissociative identity disorder can benefit from medications as well. According to Conterio and Lader (1998), Naltrexone can be prescribed to patients who dissociate. The medication can cause a self-injuring individual to feel the pain while they are injuring

themselves. Conterio and Lader stated that self-injurers might stop taking the medication in order to continue their self-injurious behavior.

There are no medications specifically aimed at alleviating symptoms associated with personality disorders, such as BPD or any of the other personality disorders. Anti-anxiety medications, which relieve some of the anxiety components of the personality disorder, have been shown to be helpful in some self-injurious individuals diagnosed with a personality disorder (Conterio & Lader, 1998).

In a recent study conducted by Whitlock, Powers, and Eckenrode (2006), it appears that adolescent self-injurers are utilizing a new form of therapy. More adolescents are utilizing the Internet as a way to connect with other individuals who also self-injure. The anonymity of the Internet allows adolescents to exchange both positive and negative feedback regarding self-injury. Whitlock et al. conducted two studies that addressed the prevalence of self-injury message boards and common topics that the boards addressed, while the second study investigated correlations between content areas. The first study isolated the following areas that were common in discussion, such as informal support and exchange, sharing techniques related to self-injury, and motivation for using self-injury. Whitlock et al. found that that the use of message boards involving the topic of self-injury had grown significantly during 1998-2000 and the current amount of sites and postings has remained consistent during 2000-2005. Based on the results of the study from Whitlock et al., the primary focus of the postings on the message boards were to provide support (28.3%), followed by the discussion of precipitating events of self-injurious episodes (19.5%). Approximately 9% of the postings addressed ways to keep self-injury a secret from others; then discussions about the addictive nature occurred

in almost 9% of the postings. Postings about seeking professional help accounted for approximately 7% of the postings, followed by the discussion of different ways to self-injure in about 6% of the postings. Other areas that were not as predominant were mental health conditions related to self-injury, references to pop culture, and the perceptions of others (Whitlock, et al.).

Another form of treatment is inpatient therapy. One inpatient therapy program is located at the Bethlem and Maudsley Hospital in London, England. This therapy program was established in 1992 and is used primarily with self-injurers who burn and cut. According to Crowe and Bunclark (2000), the program will allow patients to receive supportive medications, such as antidepressants, but only when deemed necessary. Crowe and Bunclark described two basic tenets of self-understanding in their patients. The first is that individuals need to accept responsibility for their actions. Crowe and Bunclark stressed the need to let patients choose between self-injury or a different coping mechanism. The second tenet of understanding is therapeutic risk-taking, which may occur because these individuals usually do not take responsibility for their actions.

In their program, Crowe and Bunclark (2000) stated that patients are automatically admitted for six months. This unit follows a psychosocial model and addresses the personal and social levels and needs of each patient. Crowe and Bunclark stressed the importance of providing limits in the ward to ensure safety. Crowe and Bunclark also discussed the necessity of time and having the ward mimic the outside world.

In the Bethlem and Maudsley Hospital, individual and group counseling sessions are run Monday through Friday, with a weekly group on coping skills. According to

Crowe and Bunclark (2000), many self-injurers have difficulty with verbal communication. Therefore, other forms of therapy are utilized, such as art therapy. According to the authors, these individuals need to learn how to have fun and learn how to handle social situations. Nightly activities, such as games, are offered, and residents are invited to participate (Crowe & Bunclark). Another weekly group involves recently discharged patients. They are allowed to participate in groups up to three months after discharge to discuss continuing concerns and problems. Follow-up treatment helps current and former patients realize that there is not an instant cure, but there is a goal they can achieve (Crowe & Bunclark). Family therapy is also offered to help families support the residents when they are discharged.

Crowe and Bunclark (2000) addressed the importance of staff and patient collaboration at Bethlem and Maudsley Hospital. In this important therapy program, they do not address former abuse issues. Instead, they focus on how the abuse is relived in their current situations. This program also focused on addressing alternatives to self-injury, such as art therapy or postponement tactics (e.g., going for a run or reading a book).

According to Crowe and Bunclark (2000), individuals may self-injure, but the staff and other residents are told to be neutral about the situation. For example, many residents are told to take care of their own wounds, if possible (Crowe & Bunclark). If an individual crosses certain self-injurious boundaries, such as burning oneself with an open flame, they are suspended from the program (Crowe & Bunclark).

Overall, this inpatient program supposedly provides individuals with support and freedom. The residents are reportedly well informed of the boundaries of care and what

types of incidents can have them suspended from the unit. According to Crowe and Bunclark (2000) staff members know the rules and are very supportive of the residents. The staff members are referred to as parents and act in a role similar to a parent who is neither too permissive nor too restrictive. This form of treatment is relatively new, and further research studies need to be conducted on the effectiveness of this program.

The second program is called the S.A.F.E. Alternatives® Program. The S.A.F.E. Alternatives ® Program is located in Oak Park, Illinois (Conterio & Lader, 1998). This program is considered both an inpatient and a day patient program. At intake, a determination is made as to which program will be more beneficial to the patient. Contario and Lader described this Illinois program as significantly different from other programs and treatment options. Most treatments focus on the act of self-injury and what it does to your body, as well as how it affects those around you. Most often, sharp objects are taken away from self-injurers and they are sometimes tied or forced into four-point restraints to restrict them from injuring themselves. Because of these strategies, the self-injurer often feels frustration, humiliation, and an overall sense of not having control over their actions. Often, individuals who self-injure are also told to utilize other ways to replace their self-injury, such as drawing on themselves with markers, breaking eggs over their skin, or submerging their limbs into ice cold water (Conterio & Lader).

According to Conterio and Lader (1998), the S.A.F.E. Alternatives® Program differs from many of the traditional means of treatment. Clients are treated in a respectful manner, and the responsibility of choosing to not self-injure is placed in the hands of the self-injurer (Conterio & Lader). The S.A.F.E. Alternatives ® Program is ideally setup for thirty days, but patients have the right to leave whenever they want. One of the most

important aspects of this program is that admission is not done on an emergency basis. The admission is planned ahead of time, rather than a post-event reaction to the event of self-injuring. In addition, they are able to use sharp objects under the condition that they are used for what they are intended. Individuals who enter the program are also required to sign a No-Harm contract. According to Conterio and Lader, there are occasional violations of the contract. Repeated violations can lead to discharge from the program. The staff is available to help these individuals through every stage of their stay at the facility (Conterio & Lader).

Another unique aspect to the S.A.F.E. Alternatives ® Program is that patients are discouraged from showing their scars. The rationale is that each time they show their scars, they relive the event. It prevents the individuals from using appropriate coping skills because they are just placing their emotions into another venue (Conterio & Lader, 1998). This program does not allow individuals to use other forms of injuring themselves, such as breaking eggs onto their arms or drawing on their limbs with markers. This idea is called the Pressure-Cooker Theory, where every feeling has a physical reaction associated with it (Conterio & Lader). In many instances, alternative ways of handling one's emotions cannot be accomplished in everyday society because there is not a quick way to handle everything in life. The S.A.F.E. Alternatives® Program helps patients find appropriate ways to acknowledge their feelings and think through their thought processes, ridding themselves of the all or nothing type of thinking (Conterio & Lader).

The goal of therapy is to help the individual find ways to act and think at an appropriate age level. According to Conterio and Lader (1998), this is accomplished through "education, setting limits, enforcing consequences, offering encouragement and

praise, and holding patients responsible for their actions" (p. 224). The first part of this process involves a change in attitude, which leads the patients to realize they have control over their behavior. The second aspect is that every feeling does not have a physical reaction associated with it. In some instances, this is the first time these individuals have been in a safe environment free from abuse; knowing that this type of environment does exist, it is important to recognize the feelings and concerns of others (Conterio & Lader).

The S.A.F.E. Alternatives® Program has a S.A.F.E. toolbox, which includes several items. One of the first items is the No-Harm contract, often co-authored by the patient, which is signed by the patient and therapist stating that they understand what is expected of them, as well as what is expected of the program or therapist (Conterio & Lader, 1998). Another useful tool is the Impulse Control Log where the individual writes down feelings, thoughts, and situations that are related to the thought of injuring themselves. The hope of the Impulse Control Log is to have the individual draw a connection between their thoughts, feelings, actions, and reactions. The third tool utilized by the program is called "the five alternatives" (Conterio & Lader). This is a list of five alternatives to self-injuring, such as going for a walk, writing in a journal, or working on a creative project. The fourth tool in the toolbox is writing assignments. The S.A.F.E. Alternatives® Program requires patients to complete fifteen written assignments given in a sequential order. These assignments help the patient focus on the following areas: "self-awareness, identification of feelings, family/relationship issues, and gender/body image issues" (p. 259-260). Examples of writing assignments are an autobiography, the anger inside, the person I want to be, and future plans (Conterio & Lader). Another idea utilized

by many patients is journaling, as long as journaling is used in an appropriate way, not in a self-demeaning manner (Conterio & Lader).

An important aspect of the program is to review progress and work towards moving forward, which includes analyzing what has happened in the past and applying that information to future situations. Two ways to accomplish this are to discuss the topic with the therapist and/or review the impulse log (Conterio & Lader, 1998). The next step for patients is to express feelings without injuring themselves, knowing that their feelings will not harm them. The next step is to work on a plan that does not include self-injury, but realizing that relapse may happen. The S.A.F.E. Alternatives® Program believes that relapse is part of the process, but it can be prevented by choices of the patient (Conterio & Lader). When patients are discharged from the inpatient program, there is an outpatient program that focuses on real-world issues and what is going on in their lives (Conterio & Lader).

According to Malikow (2006), treatment can include a combination of behavioral therapy, cognitive therapy, and medication. Malikow indicated that cognitive restructuring can be a technique utilized with self-injurers to teach them to think differently and restructure their thought process.

Barriers to Treatment

There are many concerns, both from patients and staff, regarding the treatment of self-injurers. A study done by Smith (2002) involved an analysis of a small population (n = 3) of self-injurers and individuals (n = 15) who worked with self-injurers in different settings. The self-injurers in this study felt they experienced the following: a) they were not listened to, b) they were considered failures by the staff because they continued to

self-injure, and c) they were treated in a negative manner by the staff. Many of the surveyed hospital staff also believed that individuals who self-injure were treated in a negative manner. One of the possible reasons for the maltreatment is the lack of information available on the subject. Another source of frustration for the staff may confusion as to where individuals who self-injure will be best served. Many agree they are not best served in an emergency hospital setting. Some believe that self-injurers will benefit from a crisis house because admission into the crisis house does not involve the stigmatization that an admission to the hospital does. Yet, community health workers are unsure if they want to work with a population that is outside the realm of severe mental illnesses because they are already involved with so many other populations. Instead, the best possible situation for working with self-injurers might be to involve several resources to gain the best possible help and treatment for these individuals.

Recommendations for individuals who work with self-injurers

Malikow (2006) made a few recommendations for teachers who work with students who self-injure. He noted that school stressors might elicit different types of emotions and behaviors, such as anxiety or aggravation. When these emotions vary and change depending on the situation, some students will resort to physical pain to separate themselves from their stressors. Malikow noted that teachers can be very important to students who self-injure because teachers can be a contact for these students and provide them with structure and expectations.

Nichols (2000) described several reasons why individuals may self-injure with different recommendations for school personnel who work with these individuals. According to Nichols, school personnel should assume the responsibility of supporting a

professional outside of the district who is working on an ongoing basis with these individuals. Nichols argued that most school counselors are not adequately trained, nor do they have the amount of time needed to work with these individuals on an ongoing basis. Nichols has offered some suggestions for school staff to work as supportive professionals with these students. These recommendations are based on the expressed reasons for the self-injury.

The first recommendation is for professionals who work with individuals who use self-injury as a stress reliever. Individuals who utilize self-injury as a stress reliever often struggle with feelings and negative personal experiences. These feelings and experiences build on each other resulting in tension. To release this tension, these individuals self-injure. School counselors should be aware of students who self-injure because some may openly display their wounds, but others will try to hide them. If self-injury is suspected, the counselor should contact a local professional and devise a plan to discuss the situation with the student and parents. One caution in working with these individuals is to remind them of the limits of confidentiality, while keeping in mind their fears about the situation, as these individuals may be embarrassed by their behavior (Nichols, 2000).

A second type of self-injurer is one who self-injures as the result of poor coping skills (Nichols, 2000). One way to work with this type of self-injurer is to start groups that teach appropriate coping skills, such as relaxation techniques and friendship skills. Working in small groups with this type of client is beneficial to helping the students focus on the issue at hand while not reliving their personal history (Nichols).

Another reason for self-injury, which aligns with poor coping skills, is poor problem solving skills. According to Nichols (2000) and Muehlenkamp (2006),

individuals with poor problem solving skills tend to avoid problems and struggle to brainstorm solutions to their problems. Nichols suggests a step-by-step approach to helping these students. The first step is to brainstorm possible solutions, then make a choice. The next step is to devise an action plan and then follow through with the plan (Nichols; and Muehlenkamp).

Another type of self-injurer is one who is unable to express her thoughts in an oral form because this student has often been told that her comments and feelings do not mean anything to anyone (Nichols, 2000). These students may benefit from assertiveness training, which helps them express their emotions. These students may also benefit from recognizing and regulating their negative self-talk (Nichols).

Another type of self-injurer is one who injures to gain attention, but the goal of this behavior may not be manipulative in intent (Nichols, 2000). Due to their need for attention, it does not matter whether the attention is good or bad. Giving them the attention they need at the appropriate times may help the individual develop more adaptive behaviors. Another suggestion is that a counselor could check with teachers to discover accomplishments the student has made within the classroom, then using these compliments to give the student the needed positive attention (Nichols). Malikow (2006) suggested that these students might also benefit from encouraging behaviors that elicit positive attention.

Some self-injurers resort to injury because they have an irrational belief system, such as believing self-injury is okay (Nichols, 2000). School personnel can help reinforce the inappropriateness of this thought by informing students that self-injury is not acceptable, while providing the student with support. Thus, school personnel should not

condone or approve of their self-injury. Another suggestion is to evaluate what message the school has about appearances (Nichols). A third suggestion is to help these students find words to express their situations. One way to help students find these words is through a social skills group or class (Nichols).

There is also a type of self-injurer who injures to find unification with a group of individuals because it increases self-esteem (Nichols, 2000). Schools can help these students by utilizing their talents and interests to increase self-worth. A group of students who self-injure is more difficult to work with because they often develop a gang mentality. One way to work with these students is to discuss problem solving techniques and to involve them within the school community to increase their self-worth (Nichols).

Another reason for self-injury is found in those who dissociate and are unable to recall important information (Nichols, 2000). This form is most often found in those who have experienced childhood trauma, such as sexual abuse. The best course of action for school personnel is to refocus the student's attention back to current tasks. Other suggestions may be obtained from a therapist (Nichols).

Poor body image is another trigger for self-injury in some individuals (Nichols, 2000). Schools can help with these issues by addressing these concerns in health or physical education classes. School personnel should be aware of these concerns and know the appropriate individuals to contact in case this situation presents itself.

Suicidal ideation is another form that may present itself within the school. Although most self-injurers are not attempting to end their lives, it can happen. They may decide they can no longer cope with their current situation or they cut too deeply and end up committing suicide (Nichols). School staff need to be aware of the limits of

confidentiality and contact the parents. Staff members who are aware of the situation should keep a record of these incidents and the school district's attempts to provide support and intervention in case the student does commit suicide (Nichols).

The last form of self-injurer is one who needs to feel in control of something in her life and resorts to injuring as the one thing that she can control (Nichols, 2000). The school can reinforce the message that the individual is in control of whether or not she chooses to self-injure. School personnel can help these students gain the skills to take control of their lives and actions (Nichols).

Malikow (2006) suggested another type of self-injurer who may be present in the school setting: one who has social anxiety. The researcher suggested that if social anxiety is a reason for the behavior, it may be beneficial to analyze what circumstances are more anxiety provoking. If a situation, such as public speaking or group work, is more anxiety producing for a student, it may be beneficial to modify the requirements to reduce the anxiety.

Summary of Literature Review

Self-injurious behavior is very complex and is exhibited in many forms. There are several factors that may explain why individuals self-injure. Some of these reasons include: sexual, physical, and/or mental abuse; substance abuse; eating disorders; and psychological disorders. Abuse can affect how an individual copes with reality. In some instances, those who have been abused are at a higher risk of self-injuring than others because the parents of the self-injurer may not have obtained the needed skills to be an effective parent. The lack of guidance and nurturing can leave a person feeling very

vulnerable and unable to cope in an appropriate way, leading them to engage in destructive coping mechanisms, such as self-injury.

Many psychological disorders occur co-morbidly with self-injury. Eating disorders, substance abuse, and body image disorders are examples of some co-morbid diagnoses. Self-injury can occur with these disorders or in some cases one form of self-injury will replace another. For example, an individual may receive treatment for an eating disorder. The individual does well with regards to eating, but replaces the control she once had over eating by controlling the self-injury.

Medications can be used with individuals who self-injure. Medications are often used when there is a co-morbid diagnosis, such as depression or an anxiety disorder. There are some issues related to medication in that some individuals may become addicted to the side effects of the medication or the individual may stop taking the medication in order to regain the experience they received from cutting (Conterio & Lader).

One of the residential programs discussed in chapter two is located in a separate wing of a hospital in London, England. The treatment program is based on a psychosocial model and attempts to address all parts of the individual: emotional, social, and cognitive. An important concept from this program is that staff and patients learn from each other (Crowe & Bunclark, 2000).

The S.A.F.E. Alternatives® Program is an inpatient and outpatient facility located in Oak Park, Illinois (Conterio & Lader, 1998). The main premise of the S.A.F.E. Alternatives® Program is that patients need to have a true desire to stop self-injuring and that the patients have the choice to self-injure. Admission to the program is not based on

a crisis situation; it is predetermined (Conterio & Lader). This program has several steps and utilizes different tools to help the self-injurer, primarily through a No-Harm Contract, Impulse Control Log, identifying non-harming options to self-injury, and specific writing assignments.

According to the authors, the S.A.F.E. Alternatives® Program has a caring staff that takes a stance of neither accepting or disapproving of an individual if she chooses to self-injure (Conterio & Lader, 1998). As the patient nears the end of the programming, there is an outpatient group that is available to her after discharge (Conterio & Lader).

Nichols (2000) offered several recommendations for school personnel to work with individuals who self-injure. Because there are several reasons for self-injury, different strategies were developed based on those reasons. An example is a self-injurer who injures as a result of poor coping skills. One response from school personnel is to help teach emotional control through techniques such as relaxation training and identifying self-help strategies to replace the maladaptive coping skills.

Critical Analysis

Research on self-injury can be somewhat confusing because there are so many variables as to why an individual may self-injure. One confusing issue involves abuse. In most instances, physical and sexual abuse are the most common forms of reported abuse in those who self-injure, yet some individuals reported emotional abuse and neglect. Conterio and Lader (1998) believed that a bond was never established between the parent and the child. Not every individual who self-injures has been abused and not every individual who has been abused self-injures. Needless to say, abuse is not a guaranteed precipitator to self-injurious behavior. There are so many individual and multiple reasons

why an individual may turn to self-injury. It would be impossible to devise a single research study to focus on every variable.

Co-morbid diagnoses have similar issues as abuse. Not everyone who has a specific disorder self-injures and not every self-injurer has a co-morbid diagnosis. More research is needed to examine how many people suffer from multiple diagnoses and if self-injury is co-morbid to these diagnoses.

The inpatient program at Bethlem and Maudsley Hospital in London has some valuable components. One of the most interesting aspects of this program is that it takes into account the knowledge and experiences of the person who self-injures (Crowe & Bunclark, 2000). Staff members are instructed to take a neutral approach to situations in which people could overreact (Crowe & Bunclark).

The reported length of stay is somewhat variable. Crowe and Bunclark (2000) stated individuals are admitted for a set time of six months, however, later in the publication it is stated that the average stay was under five months. Six months seems like a lengthy time for an initial placement. In some cases it may be warranted, but the stay could start at three months and a longer stay can be granted if needed. Crowe and Bunclark also addressed the importance that the program be as similar as possible to the outside world, as this better prepares the individuals to cope with experiences they may be exposed to when they are discharged. Another beneficial component of this program is that individuals who have been discharged are allowed to attend outpatient groups. This is important because these individuals need support after they have been released; plus, they are able to provide insights to individuals still in placement. Crowe and Bunclark did not state what these individuals do for ongoing support after the three months. They

discussed some results of their study, but future studies should address more recent findings and discuss the results in more detail.

The S.A.F.E. Alternatives® Program offers self-injurers a different type of treatment that the self-injurer may not have previously encountered. One of the most important aspects of this program is that the self-injurer takes responsibility for their actions because they are the only ones who can control them (Conterio & Lader, 1998). Another important aspect of the program is the helpful role of the staff. The S.A.F.E. Alternatives® Program uses several tools to help their patients. One of the most important tools is the Impulse Control Log. Overall, this program is very comprehensive and appears to have a good record of successful discharges. It would be interesting to see short-term and follow-up data of individuals who have successfully completed the S.A.F.E. Alternatives® Program. It would also be intriguing to find out how many insurance companies allow patients to stay in the program for the entire thirty days or if there is other funding available for individuals who cannot afford the program.

Another noteworthy aspect to Conterio and Lader's (1998) book is that they offer ways for therapists to utilize the techniques used in their program. In their book, they included copies of the No-Harm contract and Impulse Control Log, which indicates how much they are willing to help therapists, as well as those who self-injure.

Recommendations

A recommendation for future research is to assess the possibility of getting a self-injury category placed in the next edition of the *Diagnostic and Statistical Manual of Mental Disorders*. It may be beneficial to have a diagnosis included in the *DSM* to provide more continuity between mental health providers. If included in the *DSM*, health

insurance companies may be more inclined to provide monetary backing for individuals to receive therapy. Before this can be done, more research needs to be completed on other factors related to self-injury. One possibility is that self-injury may fall under a new term labeled Obsessive-Compulsive Spectrum Disorder. As of now, there has not been a great deal of research on this form of spectrum disorder. It is also a possibility that self-injury may not be classified under that category because self-injury is inflicted for many different reasons.

A further suggestion for future research would be to classify each self-injurious episode of a group of self-injurious individuals. Then, these episodes can be classified according to type of intent, like manipulative intent or tension release. It may be beneficial to be knowledgeable of the intent because it might help focus treatment options and strategies.

A third recommendation for further research is to focus on reactions of individuals involved with self-injurers. Interviews and surveys could be conducted on the reaction of parents, teachers, school counselors, staff, principals, mental health care workers, or other individuals who work with self-injurers. Depending on anticipated specific reactions from individuals, self-injurers may not confide in them about their problem with self-injury. Training could be made available to individuals who are not sensitive or knowledgeable about self-injury. Post-tests could be administered to assess the effectiveness of self-injury sensitivity training.

More research on effective interventions for those who self-injure is also recommended. If more effective interventions were developed, it could lead to easier access to local treatment options. This would decrease the time these individuals were

away from their families, increase the amount of family involvement and support, and provide easier access to outpatient therapy. It should be noted that Linehan, Comtois, Brown, Heard, and Wagner (2006) have introduced a new assessment, the *Suicide Attempt Self-Injury Interview*, that may be beneficial in future research for self-injury. The results from this instrument may be utilized to tailor more effective interventions for clients who self-injure.

There are several different prospects for future research that correspond with, or diverge from, the current literature, such as testing the perceptions of school personnel. Either way, more research is needed to clarify many aspects of self-injury, such as other possible influences that may lead a person to self-injure. Overall, self-injury is a very misunderstood concept. Hopefully, more research will clarify self-injury and this knowledge can be dispersed to individuals who self-injure and to people who work or live with those who self-injure.

Chapter III: Methodology

Introduction

This chapter includes information about how the sample was obtained, a description of the sample, and the instrument used. In addition, data collection and data analysis are described. This chapter concludes with the methodological limitations of the present study.

Subject Selection and Description

The participants were randomly selected from a list of school counselors (n = 2,021) obtained from the Wisconsin Department of Public Instruction website. The list was reorganized in order to eliminate duplicates, as counselors may work in more than one building or district. From this list, 300 school counselors were randomly selected. Those selected counselors were mailed an invitation for participation (located in Appendix A) and the survey. (The survey is located in Appendix B.) Both male and female counselors from elementary, middle, and high schools were asked to participate in this study.

There were 187 surveys returned (62% return rate), of which 186 were analyzed. One form was completed by a school psychologist and excluded from the analysis. The sample consisted of 50 male and 136 female counselors. The vast majority of the sample (n = 183) indicated their ethnicity was Caucasian. The other ethnicities of the respondents were Asian/Pacific Islander (n = 2) and African American (n = 1). Counselors were working with the following grade levels at the time of the survey (please note that one respondent did not indicate a grade level): Kindergarten (n = 48); first grade (n = 51); second grade (n = 51); third grade (n = 50); fourth grade (n = 50); fifth grade (n = 57);

sixth grade (n = 77); seventh grade (n = 85); eighth grade (n = 86); ninth grade (n = 97); tenth grade (n = 98); eleventh grade (n = 99); twelfth grade (n = 99); and Other (n = 4). Of the four respondents that indicated "Other," one respondent indicated that they were also the K-12 AODA coordinator, one respondent did not indicate an answer, and the remaining respondents (n = 2) stated they also worked in the alternative school.

The counselors surveyed were also asked to indicate the population demographic of the school and/or schools in which they work. Most respondents (n = 183) answered the question. The school demographics were as follows: Urban (n = 22); suburban (n = 62); rural (n = 91); urban/suburban/rural (n = 1); suburban/rural (n = 4); urban/suburban (n = 2); and other (n = 1). The other respondent indicated that the demographics of the school are a small community with some farms. Counselors were also asked to indicate the amount of years they have worked as a school counselor. The responses were as follows: 0-5 years (n = 33); 6-10 years (n = 40); 11-20 years (n = 73); 21-30 years (n = 30); 31 years or longer (n = 9); and missing response (n = 1).

Instrumentation

The researcher developed a survey containing eleven questions for the purposes of this study (see Appendix A). The first four questions of the survey inquire about demographic information, including gender, ethnicity, grade levels with which the counselor works, population demographic of the school(s) in which they work, and years of experience as a counselor. One question asks if the school counselor learned about self-injury in their graduate program and/or practicum experiences. The next two items ask for the school counselors' initial and current perceptions of the reasons why students self-injure. The next item addresses whether the counselors have worked with students

who self-injure. If the counselors answered no to this question, they were asked to discontinue responding to the items and mail the survey back to the investigator in the enclosed postage-paid envelope. If the counselors answered yes, they were asked to quantify the number of students they have counseled regarding their self-injurious behavior. The next question asked the counselors to indicate the types of interventions they have utilized and/or recommended when working with students who self-injure. The final question asked the counselors to indicate the grade levels of the students they counseled about self-injurious behaviors. In addition, counselors had the option of providing additional comments or information at the end of the survey.

Data Collection Procedures

Data collection occurred during the fall semester of 2006. The counselors were mailed an invitation to participate in the study. The invitation included a description of the study, possible risks and benefits of participation, a statement of confidentiality, and the survey. The initial mailing was sent to the counselors at the beginning of October 2006. A reminder mailing was sent at the end of October.

Data Analysis

The data were analyzed using the computerized statistics package named SPSS-X. A series of two-sided Pearson chi square analyses using a .05 probability of error were conducted to test for associations between participant gender and level in which the school counselor worked (i.e. elementary, middle, and/or high school). The data was also analyzed to identify any associations between school counselors' initial and current perceptions of student self-injury. Additional analysis was completed to determine whether the level of counselor experience and training with self-injury was associated

with their perceptions of self-injury. The school counselors' level of experience and the number of self-injurious students with which they have worked were also attained.

Limitations

One limitation of this study is that not all forms of self-injurious behavior, such as drug and alcohol abuse and/or dependency and eating disorders, were included. Another limitation of this study is that the technical adequacy, including reliability and validity, of the survey instrument, has not been examined. Further, only school counselors from the state of Wisconsin were asked to participate in the study; therefore, any results obtained from this study should not be generalized to counselors in other states or districts, or to other professionals.

Chapter IV: Results

The primary purpose of this paper was to gain a better understanding of Wisconsin school counselors' perceptions of student self-injury. A randomly selected group of 300 counselors was asked to respond to a questionnaire. The responses from the returned questionnaires were analyzed. The primary purpose of this chapter is a description of the findings.

Associations Between Counselor Experience and Perceptions of Self-Injury

There was a positive association between counselor experience and initial perceptions that self-injury is a possible indicator of abuse, $\chi 2\ (3) = 8.258$, $p = .041$. For frequencies related to this positive association, please consult Table D1. There was also a positive association between counselor experience and the initial perceptions that self-injury is related to the inability to verbally express problems, $\chi 2\ (3) = 8.707$, $p = .033$. Frequencies regarding this item are shown in Table D1. In both of these associations, the counselors with 11-20 years of experience more often indicated these initial perceptions than did the other experience groups.

Associations Between Counselor Training and Perceptions

There was a positive association between graduate school and/or practicum training and the initial perception that self-injurious behavior was related to an irrational belief system, $\chi 2\ (1) = 6.632$, $p = .01$. For the frequencies related to this association, please consult Table D2.

There was also a positive association between graduate school and/or practicum training and current perceptions that self-injurious behavior was related to poor body image, $\chi 2\ (1)=5.828$, $p= .016$. See Table D3 for frequencies.

There was also an association between graduate school and/or practicum training and current perceptions that self-injurious behavior was related to suicidal ideation, $\chi 2$ (1) = 3.910, p = .048. Those without training more frequently reported that self-injury was not related to suicidal ideation. Please see Table D3 for the frequencies related to this association.

Associations Between Training and Counseling of Students

There were positive associations between graduate school and/or practicum training and frequency of counseling students with self-injurious behaviors in high school at all grade levels, as shown in Table 1. Please see Table D4 regarding the frequencies related to these associations.

Table 1

Associations Between Counselor Training and Counseling Students who Self-Injure

Grade	*df*	$\chi 2$	*p*
Ninth	1	6.004	.014
Tenth	1	4.786	.029
Eleventh	1	5.252	.022
Twelfth	1	3.980	.046

Associations Between Counselors' Perceptions

There were significant changes in frequency between school counselors' initial and current perceptions of student self-injury, in the following areas: stress reliever;

attention; control; poor body image; suicidal ideation; possible abuse victim; poor problem solving skills; inability to verbally express problems; and poor coping skills. For all but two variables, the highest frequency of change was from not initially perceived to currently perceived. The opposite relationship was found for attention. For suicidal ideation, the change in direction was somewhat divided in both directions. Please see Table 2 for analysis results, and Table D5 for frequency distributions.

Table 2

Associations Between Initial and Current Perceptions Related to Self-Injury

Initial/Current Perception	*df*	$\chi 2$	*p*
Stress Reliever	1	10.412	.001
Attention	1	4.169	.041
Control	1	15.314	.000
Poor Body Image	1	17.738	.000
Suicidal Ideation	1	18.224	.000
Possible Abuse Victim	1	20.520	.000
Poor Problem Solving Skills	1	28.624	.000
Inability to Express Problems	1	27.731	.000
Poor Coping Skills	1	16.483	.000

Level of Experience and Perceptions of Self-Injury

There were no associations between the school counselors' level of experience and initial perceptions that the reason for self-injury was due to any of the following: suicide attempt; stress reliever; attention; control; irrational belief system; poor body image; suicidal ideation; unification with group; poor problem solving skills; and poor coping skills. Please consult Table C1 for the statistical results.

There were also no associations between school counselors' level of experience and current perceptions that the reason for self-injury was due to any of the following: stress reliever; attention; control; poor body image; suicidal ideation; possible abuse victim; poor problem solving skills; inability to verbally express problems; and poor coping skills. Please see Table C2 for the statistical analyses results.

Items Related to Experience as a Counselor

The association between years of experience as a school counselor and whether they had counseled at least one student about their self-injurious behavior could not be tested, as there was a minimum requirement violation. Of the counselors surveyed, a majority (n = 166) had counseled students about self-injurious behavior. The counselors who answered "yes" were asked to further explain how many students they had counseled about their self-injurious behavior. There was no association between years of experience and the number of students counseled about their behavior, $\chi 2\ (15) = 15.362$, $p = .426$.

There was no association between years of experience as a counselor and use of individual counseling as a type of intervention, $\chi 2\ (3) = 2.991$, $p = .393$. There was also no association between years of experience and those who used, recommended,

used/recommended, or no answer given for individual counseling, $\chi 2$ (9) = 6.327, p = .707. Additionally, there was no association between years of experience as a counselor and use of group counseling as an intervention for this population, $\chi 2$ (3) = 2.775, p = .428. Of those who responded "yes" to group counseling, there was no association between years of experience as a counselor and using, recommending, and using/recommending group counseling, $\chi 2$ (6) = 7.412, p = .284. An analysis of the final item addressing interventions showed no association between years of experience as a school counselor and using another type of intervention, $\chi 2$ (3) = 2.645, p = .450. Of the respondents who answered "yes," there was no association between another type of intervention used, recommended, used/recommended, and no answer given, $\chi 2$ (9) = 2.246, p = .987. Of the respondents who indicated they have used and/or recommended another intervention (n = 66), these responses were classified by category. The primary category was a referral to another outside agency, such as counseling, family counseling, hospitalization, and mental health agencies (n = 37). Several respondents (n = 16) indicated that they would inform the parent. To a lesser degree, some counselors would use other forms of therapy in the school setting, such as bibliotherapy (n = 4), videos (n = 1), reality therapy (n = 1), control therapy (n = 1), journaling (n = 1), art therapy (n = 1), and other creative strategies (n = 1).

There was no association between counselors' experience counseling a student who self-injures and the grade levels they have counseled in the following grades: kindergarten; second; third; fourth; fifth; sixth; seventh; eighth; ninth; tenth; eleventh; and twelfth. Please consult Table C3 for statistical analysis results. No analysis was

conducted for first grade because no counselor indicated they had counseled a student who was in first grade about their self-injurious behaviors.

Items Related to Training

The next area addressed training in graduate school and/or practicum experiences and counselors' initial perceptions of self-injurious behavior. There was no association between training and initial perceptions that self-injury is related to the following: suicide attempt; stress reliever; attention; control; poor body image; suicidal ideation; possible abuse victim; unification with group; poor problem solving skills; inability to verbally express problems; and poor coping skills. Please see Table C4 for statistical analysis results.

The relationship between training in graduate school and/or during a practicum experience and counselors' current beliefs was also analyzed. There was no association between training and school counselors' current beliefs regarding self-injurious behavior in the following areas: attention; control; possible abuse victim; poor problem solving skills; inability to verbally express problems; and poor coping skills. Please consult Table C5 for statistical analysis results.

There was no association between training and whether counselors had worked with at least one student who has participated in self-injury, $\chi 2\ (1) = .249$, $p = .617$. The association between training and the amount of students a counselor had counseled regarding self-injury could not be tested due to a minimum frequency violation.

There was no association between training and the use of individual counseling as an intervention, $\chi 2\ (1) = .949$, $p = .330$. The association between training and whether a counselor used, recommended, and used/recommended individual counseling was unable

to be analyzed due to a minimum frequency violation. There was no association between training and the use of group therapy as an intervention for this population, $\chi 2$ (1) = .992, p = .319. There was also no association between training and whether the counselor used, recommended, and used/recommended group therapy, $\chi 2$ (2) = .561, p = .755. There was also no association between training and whether the counselors used another type of intervention, $\chi 2$ (1) = .806, p = .369. The association between training and whether or not a counselor used, recommended, or used/recommended another type of intervention was unable to be analyzed, due to a minimum frequency violation.

There were no associations between training and the grade level of the students that the school counselors counseled about self-injurious behaviors in the following grades: kindergarten; second; third; fourth; fifth; sixth; seventh; and eighth. Please see Table C6. No statistics were computed at the first grade level, as this level was a constant.

Additional Comments

The school counselors who participated in the study were also invited to provide comments regarding self-injurious behavior. The comments encompassed five areas, including: insights into possible reasons for self-injury; referral; difficult topic to counsel; training; and additional ideas. Some counselors suggested various possible reasons for self-injury, including attention, a form of bonding with peers, a fad behavior, a common way to handle problems, and emotional issues. In the area of referral, some counselors have had students referred to them, while other counselors have referred these students to the school social worker or school psychologist. Several counselors indicated that self-injury is a difficult topic to counsel, as there are some ethical considerations, such as

breadth of school counselor license, as well as ethical obligations, such as telling or not telling a student's parents. Several counselors (n = 6) suggested that counselors, as well as parents, would benefit from training to identify students who utilize self-injury. Two counselors offered resources for counselors to use when working with students who self-injure. One recommendation was a book and the other suggestion identified a speaker located in the Madison, Wisconsin area, as they found this information very useful. For a detailed listing of comments, please consult Table C7.

Chapter V: Discussion

The primary purpose of this paper was to assess Wisconsin school counselors' perceptions of student self-injury. The survey was developed by this researcher to obtain demographic information, how the counselors might have learned about self-injury, perceptions of self-injury, and information about their experience, if any, in working with students who self-injure. Several associations among the variables were found. The purpose of this chapter is to suggest possible explanations for the results, as well as to suggest recommendations for further research.

Limitations

One limitation of this study is that not all forms of self-injurious behavior, such as drug and alcohol abuse and/or dependency and eating disorders, were included. Another limitation of this study is that the technical adequacy, including reliability and validity, of the survey instrument, has not been examined. Further, only school counselors from the state of Wisconsin were asked to participate in the study; therefore, any results obtained from this study should not be generalized to counselors in other states or districts, or to other professionals.

Conclusions

Although little research regarding self-injury has been done, it is certainly a topic gaining more attention. Although there is an increase in the research, there has been little, if any, research related to school staff members' perceptions of student self-injury. This survey was conducted in order to gain some perspective into school counselors' perceptions of and experience with students who self-injure.

Based on information obtained from the surveys, school counselors appear knowledgeable of the resources available to them, as several counselors indicated utilizing books, workshops, as well as mental health professionals and other colleagues, to obtain information regarding self-injury. To a lesser extent, some counselors indicated they have used the internet, hospital staff, and other forms of information. It appears that school counselors know how to access and find information regarding self-injury. However, it is an evolving topic; new information continues to be gained. Some counselors might attend workshops or read books about self-injury, but without working on a regular basis with students who self-injure, it may be difficult to recall specific strategies when the situation is present. It was noted by several individuals that a yearly in-service would help refresh their memories about what to look for and how to work with a student who self-injures.

Self-injury is also a topic that can cross ethical boundaries, which might impact counselors' contact with students. Some counselors indicated that they might meet with a student, but then would refer the student to an outside mental health professional due to training, as well as the amount of time needed to work with students who self-injure. School counselors usually provide short-term counseling. A student who self-injures likely requires intensive, long-term counseling, which a school counselor, in most circumstances, is unable to provide. Some counselors likely struggle with the ethical component of self-injury. Some students might not confide in a counselor if they know the counselor will contact their parents, yet a counselor is a mandated reporter and required to contact a parent or another authority, such as a social worker, if they harm themselves.

Based on the results of the survey, counselors with 11-20 years of experience reported higher frequencies of initial perceptions that self-injury might be a result of having been abused by others than counselors who had the fewest years of experience (0-5 years). There was also a positive association between having 11-20 years of experience and initial perceptions that self-injury is related to students' inability to verbally express their problems, in contrast to counselors with 21 years or more experience. There are several possible reasons for these associations. The counselors who had been counseling for 11-20 years in districts and/or buildings where there is more than one counselor might be receiving the most referrals for students who self-injure because they may be perceived as having the most expertise in the area of self-injury and good rapport building skills. These counselors might also be more comfortable working with students who self-injure than those with different levels of experience. Finally, it may be that this group of counselors had the most specific training in the reasons for self-injury.

There was an association between whether counselors had received graduate and/or practicum training and their initial beliefs that self-injury might be the result of an irrational belief system. Some school counselors might have had experience or recalled learning this information in graduate school or during their practicum. Graduate training and/or practicum experience was also associated with current beliefs that self-injury might result from poor body image and suicidal ideation. One possible explanation for this association is that counselors might have been more familiar with research in this area, thus influencing their views regarding self-injury. These counselors may have also worked with a student or students who have self-injured and noted the students were unhappy with their body or had some suicidal thoughts or ideas.

Another association found was between graduate and/or practicum training and the number of students counseled. This association was present for counselors of students in the ninth, tenth, eleventh, and twelfth grades. It appears that the counselors who received some form of training reported counseling more students about self-injury. One explanation for this finding could be that students are very perceptive and might seek out individuals who are more comfortable and more experienced in working with self-injury. Also, in larger districts, some counselors without experience might refer a student to a different counselor who has experience in this area. Counselors who have a good bond with students may receive additional referrals from these students, or the students might disclose that another student is self-injuring. The literature indicates that self-injury is more common as students enter high school, possibly related to stressors in the high school setting. Thus, the number of high school students who are counseled regarding self-injury would be expected to increase by school level.

There were also significant changes in frequency between school counselors' initial and current perceptions of student self-injury in the following areas: stress reliever; attention; control; poor body image; suicidal ideation; possible abuse victim; poor problem solving skills; inability to verbally express problems; and poor coping skills. These changes may indicate that many counselors became more educated over time, either academically, from experience with students, or both. The majority, though, showed consistency in their beliefs over time. As these counselors gained more knowledge and experience working with students who self-injure, their initial perceptions may have been reinforced.

The optional comments provided by the counselors indicate that self-injury is a major topic of concern that would benefit from more attention. Some of the comments also indicated a need to have more resources and information to help work with students who self-injure.

Recommendations

There are several recommendations for future research. The first recommendation is to correct an error in the survey used in this study. Due to an undetected researcher error, four of the choices that were present on the initial perceptions of self-injury item were not presented as choices in the current perceptions of self-injury item. It is believed that this error restructured the range of the results because counselors were unable to mark these choices, if applicable, for the latter item.

Another recommendation is to have a small focus group of selected participants to preview the survey. Although this researcher had several counselors review the survey, it would be beneficial to have approximately twenty counselors review the survey, in order to assure the items are stated in a clear and concise manner. One example of this concern is the question asking counselors to indicate whether they had used or recommended a type of intervention. Several counselors responded in the affirmative, but did not indicate whether they used or recommended that option, or both.

The main recommendation for further research is to broaden the definition of the population being surveyed. At this time, the survey results can only be generalized to school counselors in the state of Wisconsin. It would be beneficial to include a national sample of school counselors, as well as other school personnel, mental health professionals, parents, and youth.

Overall, self-injury is a growing concern. It is believed that further research in this area is needed. More knowledge about self-injury would widen the network of individuals students can access to get assistance regarding this difficult and confusing behavior.

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Appendix A: Invitation for Participation

Consent to Participate in UW-Stout Approved Research

Title: Wisconsin School Counselors' Perceptions of Student Self-injury

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Description: The purpose of this study is to investigate Wisconsin public school counselors' perceptions of self-injury by students. For the purpose of this study, self-injury is defined as follows: Deliberate, repetitive, impulsive, non-lethal harming of one's self. Self-injury includes: 1) cutting; 2) scratching; 3) picking scabs or interfering with wound healing; 4) burning; 5) punching self or objects; 6) infecting oneself; 7) inserting objects in body openings; 8) bruising or breaking bones; 9) some forms of hair pulling, as well as other forms of bodily harm (S.A.F.E. Alternatives ® Program, 2002, n.p.). This term does not include self-injury related to sexual pleasure, eating disorders, or alcohol or other drug abuse. This term also does not include tattooing or piercing, unless a physical high and repetitive need is gained through the tattooing and/or piercing.

Risks and Benefits: Any potential risks of participation are exceedingly small. The information is being sought in a manner so that no specific identifiers are needed and so that confidentiality is maintained. Each label and return envelope has been assigned a number in order to mainstream the data collection process and minimize duplicate mailings. This identifier is only available to the researcher and research advisor. The envelopes will be separated from the survey and the surveys will be stored in a separate location. The coding system, along with the envelopes, will be destroyed after the reminder mailing. The benefits of this survey are to increase knowledge related to school counselors' perceptions of self-injurious behaviors by students. A final report of the study may be found online through the University of Wisconsin-Stout Library Catalog. Only basic demographic information about schools represented in the study will be disclosed.

Time Commitment: Please take a few minutes to answer the questions contained in this packet. Please answer the questions completely and honestly in order to best represent your perceptions. If you need additional space to add comments, please utilize the backside of the survey. Upon completion, please return the survey in the envelope provided by **October 13, 2006**. One reminder mailing will be sent after that date if the survey is not returned.

Confidentiality: Your responses will be kept strictly confidential. Your name will not be included on any documents. Only the primary researcher or designee will have access to the confidential raw data. Thank you for your help in this important research related to school counselors' perceptions of self-injury by students.

Right to Withdraw: Your participation in this study is entirely voluntary. You may choose not to participate without any adverse consequences to you. However, should you choose to participate and later withdraw from the study, there is no way to identify your anonymous document after it has been returned to the investigator.

Inquiries: All inquiries regarding this study should be addressed by contacting the researcher, Leah Johnson-Freer, or research advisor, Dr. Helen Swanson. Any concerns about the use of participants in the research should be addressed to the IRB Administrator, Sue Foxwell.

IRB Administrator: Sue Foxwell, Research Administrator
Research Services
152 Vocational Rehabilitation Building
University of Wisconsin-Stout
Menomonie WI 54751
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Statement of Consent: By completing this survey, you agree to participate in the project entitled, "Wisconsin School Counselors' Perceptions of Student Self-injury."

Appendix B: Survey

This research has been approved by the UW-Stout IRB as required by the Code of Federal Regulations Title 45 Part 46.

Student Self-Injury Survey

1. Please indicate your gender.
   ____ Male ____ Female

2. Please indicate your ethnicity. Check all with which you identify.
   ____ African American ____ Asian/Pacific Islander ____ Caucasian
   ____ American Indian/Alaskan Native ____ Hispanic ____ Other:
   _____

3. What grade level(s) are you currently responsible for as a school/guidance counselor (please mark all that apply)?
   ____ Pre-K/Kindergarten ____ Fourth Grade ____ Eighth Grade ____ Twelfth Grade
   ____ First Grade ____ Fifth Grade ____ Ninth Grade ____ Other (please list)
   ____ Second Grade ____ Sixth Grade ____ Tenth Grade
   ____ Third Grade ____ Seventh Grade ____ Eleventh Grade
   _____

4. How would your describe the population demographic of the school(s) you work at?
   ____ Urban ____ Suburban ____ Rural

5. How many years have you worked as a school/guidance counselor?
   ____ 0-5 years ____ 6-10 years ____ 11-20 years ____ 21-30 years ____ 31 years or more

6. Did you receive instruction in how to work with students who self-injure in your graduate program or practicum/internship experiences?
   ____ Yes, Graduate Program Training ____ Yes, Practicum/Internship Experience
   ____ No, Graduate Program Training ____ No, Practicum/ Internship Experience

7. How, if at all, did you obtain additional information to work with students who self-injure? Check all that apply.
   ____ Books ____ Hospital Staff ____ Continuing Education Credits
   ____ Internet ____ Other Colleagues ____ Outside Mental Health Professionals
   ____ Workshops ____ Other (please list)
   _____

8. What were your initial perception(s) of reasons for student self-injury, before learning anything about its causes? Please indicate all reasons that apply.
   ____ Suicide attempt ____ Irrational belief system ____ Unification with group
   ____ Stress reliever ____ Poor body image ____ Poor problem solving skills
   ____ Attention ____ Suicidal Ideation ____ Inability to verbally express problems
   ____ Control ____ Possible abuse victim ____ Poor coping skills
   ____ Other (please list)
   _____ _____

9. What do you currently believe are reasons why a student self-injures? Please mark all reasons that apply.

___ Stress reliever ___ Poor body image ___ Poor problem solving skills
___ Attention ___ Suicidal ideation ___ Inability to verbally express problems
___ Control ___ Possible abuse victim ___ Poor coping skills
___ Other (please list)

_____ _____

10. Have you ever counseled students who self-injure about this behavior?

___ Yes
If yes, approximately how many students have you counseled about their self-injurious behavior?
___ 0-5 ___ 6-20 ___ 21-50 ___ 51-100 ___ 101 or more
___ No (If you answer no, you have completed the survey-thank you for your time)

YES group, please continue survey on back→→

11. What types of interventions have you used and/or recommended for students who self-injure? Check all that
apply, and write a U and/or R next to each check to indicate the type Used and/or Recommended.

_____ / _____ Individual Counseling

_____ / _____Group Therapy

_____ / _____Other (please list)

_____ _____

12. At what grade levels have you counseled students who have engaged in self-injurious behaviors?
Please mark all that apply.

___ Pre-K/Kindergarten ___ Fourth Grade ___ Eighth Grade ___ Twelfth Grade
___ First Grade ___ Fifth Grade ___ Ninth Grade ___ Other (please list)
___ Second Grade ___ Sixth Grade ___ Tenth Grade
___ Third Grade ___ Seventh Grade ___ Eleventh Grade

_____

Comments (optional):

Thank you for taking time to complete this survey. I appreciate your help!!

Appendix C: Association Tables

Table C1

Associations Between Level of Experience and Initial Perceptions Related to Self-Injury

Initial Perception Area	*df*	$\chi 2$	*p*
Suicide Attempt	3	3.500	.321
Stress Reliever	3	6.001	.112
Attention	3	1.447	.695
Control	3	3.747	.290
Irrational Belief System	3	.443	.931
Poor Body Image	3	1.346	.718
Suicidal Ideation	3	.150	.985
Unification with Group	3	1.124	.771
Poor Problem Solving	3	1.111	.774
Poor Coping Skills	3	.259	.968

Table C2

Associations Between Level of Experience and Current Perceptions Related to Self-Injury

Current Perception Area	*df*	$\chi 2$	*p*
Stress Reliever	3	.425	.935
Attention	3	.761	.859
Control	3	2.787	.426
Poor Body Image	3	3.875	.275
Suicidal Ideation	3	2.218	.528
Possible Abuse Victim	3	2.997	.392
Poor Problem Solving	3	.613	.893
Verbal Expression	3	3.921	.270
Poor Coping Skills	3	3.895	.273

Table C3

Associations Between Counselor Experience and Grade Level

Grade Level	*df*	$\chi 2$	*p*
Kindergarten	3	3.362	.339
Second	3	4.418	.220
Third	3	1.266	.737
Fourth	3	1.872	.599
Fifth	3	2.857	.414
Sixth	3	2.384	.497
Seventh	3	5.502	.138
Eighth	3	3.970	.265
Ninth	3	2.904	.407
Tenth	3	2.650	.449
Eleventh	3	1.570	.666
Twelfth	3	.091	.993

Table C4

Associations Between Training and Initial Perceptions of Self-Injury

Initial Perception Area	*df*	$\chi 2$	*p*
Suicide Attempt	1	.108	.743
Stress Reliever	1	.320	.572
Attention	1	.002	.964
Control	1	.045	.832
Poor Body Image	1	.740	.390
Suicidal Ideation	1	.339	.560
Possible Abuse Victim	1	1.875	.171
Unification with Group	1	.000	.989
Poor Problem Solving Skills	1	.063	.802
Inability to Express Problems	1	.668	.414
Poor Coping Skills	1	.845	.358

Table C5

Associations Between Graduate/Practicum Training and Current Perceptions of Self-Injury

Initial Perception Area	*df*	$\chi 2$	*p*
Stress Reliever	1	.235	.628
Attention	1	.585	.444
Control	1	.090	.764
Possible Abuse Victim	1	.043	.836
Poor Problem Solving Skills	1	.443	.506
Inability to Express Problems	1	.109	.742
Poor Coping Skills	1	.352	.553

Table C6

Associations Between Training and Grade Level Counseled

Grade Level	*df*	$\chi 2$	*p*
Kindergarten	1	.476	.490
Second	1	.601	.438
Third	1	3.457	.063
Fourth	1	.006	.936
Fifth	1	.470	.493
Sixth	1	.257	.612
Seventh	1	.320	.571
Eighth	1	.179	.672

Table C7

School Counselors' Comments Regarding Self-Injury

Counselor	Comment
1.	The book "See My Pain" helped a lot. It also confirmed that my instincts about the issue were "on." I do a lot of journaling using the activities and have helped a lot of kids learn new coping skills and stop self-injuring. If you want to contact me: Please see survey. Good luck with your research!
2.	I have questioned students on self-injury behavior because a suspicion has been reported to me.
3.	I didn't receive survey until 10-13-06
4.	It is my belief that students who engage in SIB have emotional issues that can only be addressed through ongoing, in depth counseling. At the school level we view our role as that of crisis intervention, parent contact, student support. All with the goal of connecting them to services in the community.
5.	I do not have a whole lot of experience with cutting. I am not sure I am a good source of info. Also note I rec. it in the mail on 10-16-06.
6.	Received survey 10-17-06
7.	I didn't receive this until October 18th, so I apologize for it being late.
8.	It would be nice to get your research results/findings when complete.
9.	Since I am not a trained (licensed) therapist, I do not feel it is appropriate for me to "counsel" students on this behavior. I can help them process how they are currently doing, etc. and refer them and their parents for help.
10.	More training needs to be available for professionals and parents! Thanks for your interest in this topic!
11.	I worked at middle school (gr. 7-8) for the past 10 years. This current year is my first year with high schoolers.

12. Thanks
13. FYI I didn't get this survey until 10/16

14. Information for school counselors is helpful and welcome!

15. In-service yearly all counselors on this sign of problem!

16. I believe there are many students in middle and high school who self-injure-it has almost become a "fad", however I do realize it can become addictive behavior so that is not to minimize the significance of the behavior. I have to wonder how many elementary students are secretly self-injuring because of the prevalence among the older, mostly female population.

17. Good luck with your research! You have a good topic and one that certainly needs more attention.

18. Good luck on your thesis!

19. This would be a good topic for the convention (Stevens Point)

20. Good luck!

21. Complicated and confusing. Yes. Much is serious....more and more, much is also "girl's bonding" and "girl's dramatic bid for attention!" They have admitted as much.

22. Sorry this is late.

23. I have seen some "copycat" behavior that looks like SI, especially in the 5th-7th graders. One student (usually a popular one) will do it first and then several others (usually friends) will start also. All of them usually have some "issues" though. I have also seen several males who self-injure

24. Counselors need more training in this area. Parents need workshops too.

25. Good luck! I think it's an important concern.

26. I attended an excellent workshop in Madison called Self Injurious Behavior; Assessment, Treatment, and the Recovery Process Presented by Andrew Levander, MA, MAC

27. Some (most) of my inventions were at a previous job.

28. I think self-injury has a wide spectrum. Those who dabble (scratch) and those who are hardcore. The scary thing that I have noticed as a counselor is that cutting has become a more acceptable way to deal with problems amongst teens. Students are not as shocked to find out a friend is cutting because it has become a more common means of handling problems.

29. I think self-injury is completely misunderstood by most professionals. Teachers and other educational staff need training in this area...badly!

30. Difficult situations to handle because one has to decide if they tell parents or not. May lose confidence of student, but parents often need and want to know.

31. I dealt with most of my self-injury cases during my practicum experience at high school.

32. Good luck!

33. This data is from my old school district, where I was for 4 years. I am new to the Sussex School District and have not had to deal with any cutting or self-injure students.

34. I don't have as much background with middle school students as I only work with them two periods per day. Most of my time is with high school students. Hope you get some usable results from this process.

35. In a previous position as a 4-8 counselor

36. We haven't run into this at the elementary level very often. When we have, the students see the school psychologist.

37. Students who self-injure are referred to our social worker

38. What I've figured out the hard way while working with SIB is that it's not so much getting to the destination of no cutting/injury but a process that you go on with the individual. This process allows you to both look at patterns of behavior, triggers, and underlying issues. Good luck with your research!

39. Last year my school district reconfigured the two K-8 buildings. Now I only work with the younger students.

40. Difficult topic difficult to counsel

Appendix D: Frequency Tables

Table D1

Associations Between Experience and Initial Perceptions of Abuse and Inability to Verbally Express Problems

Years of Experience	Yes (1)	No (2)	Yes (3)	No (4)
0-5 Years	10	23	21	12
6-10 Years	25	15	15	25
11-20 Years	31	42	30	43
21 Years or more	16	23	12	27

Yes (1): Participant indicated that self-injury might be related to abuse.

No (2): Participant did not indicate that self-injury might be the result of abuse.

Yes (3): Participant indicated that self-injury might be the result of an inability to verbally express problems.

Yes (4): Participant indicated that an inability to express problems was not a reason why students self-injure.

Table D2

Associations Between Training and Initial Perceptions of Irrational Belief System

Training	Yes	No/Not Checked
Yes	15	43
No	14	113

Table D3

Associations Between Training and Current Perceptions of Poor Body Image or Suicidal Ideation

Training	Yes (1)	No (2)	Yes (3)	No (4)
Yes	30	28	26	32
No	42	85	38	89

Yes (1): Participant indicated an association between self-injury and poor body image

No (2): Participant did not indicate an association between self-injury and body image

Yes (3): Participant indicated an association between self-injury and suicidal ideation

No (4): Participant did not indicate an association between self-injury and suicidal ideation

Table D4

Frequencies for Counselor Training and Counseling Students who Self-Injure by Grade Level

Training	9-Yes	9-No	10-Yes	10-No	11-Yes	11-No	12-Yes	12-No
Yes	39	14	37	16	37	16	32	21
No	60	52	58	54	57	55	49	63

Note: This table provides information related to whether a counselor obtained training during graduate school or practicum experience and whether or not they counseled students about self-injury in grades 9-12.

Table D5

Frequencies for Initial and Current Perceptions Regarding Self-Injury and Potential Reasons for Self-Injury

Initial Perception	Current Perception-Yes	Current Perception-No
Stress Reliever		
Yes	75	16
No	58	37
Attention		
Yes	67	61
No	21	37
Control		
Yes	78	7
No	69	32
Poor Body Image		
Yes	38	25
No	35	88
Suicidal Ideation		
Yes	39	35
No	25	87
Abuse		
Yes	66	16
No	50	54
Poor Problem Solving		
Yes	53	10
No	53	70

Inability to Verbally Express Feelings		
Yes	74	4
No	66	42
Poor Coping Skills		
Yes	96	12
No	50	28